

I DO MY JOB, NOW YOU DO YOURS:  
HOW OREGON’S WORKERS’ COMPENSATION SYSTEM HAS  
FOUND SAVINGS IN A TIME OF COSTLY CARE

by  
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*In the 1980s, Oregon’s workers’ compensation system was among the costliest in the nation. The state’s premium rates ranked sixth highest in the country and it had one of the nation’s highest occupational injury and illness rates. However, thirty years later, Oregon is one of the most cost-effective workers’ compensation systems in the country with premium rates at 69% of the national median.*

*While Oregon has succeeded in controlling medical costs and lowering employer premiums, the state has indirectly curtailed access to benefits. This Article examines Oregon’s recalibration of its workers’ compensation system through the introduction of higher initial compensability standards and mandatory managed care enrollment for accepted claims and suggests new opportunities to expand access to low costs health care providers and curb litigation spending.*

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## I. INTRODUCTION

Larson's seminal text on workers' compensation law describes workers' compensation as "a system, not a contest, to supply security to injured workers and distribute the cost to the consumers of the product."<sup>1</sup> While simple and eloquent in tone, the trickle-down notion of workers' compensation ignores the complexities inherent in insurance contracted healthcare. This Article examines Oregon's cost-effective workers' compensation system by considering how the marriage between insurers and managed care organizations (MCOs), along with legislative changes in claim compensability, have lowered the cost of providing care while also limiting access to care.

## II. THE WORKERS' COMPENSATION DOCTRINE

### A. *Workers' Compensation vs. Social Insurance*

The United States' workers' compensation system has been referred to as the nation's first social insurance.<sup>2</sup> The adoption of compulsory workers' compensation insurance statutes by the states undoubtedly paved the way for future social insurance programs,<sup>3</sup> but it is best to distinguish workers' compensation from social insurance for the following reasons: 1) the parties responsible for shouldering the cost of injured worker care is not the public at large and 2) workers' compensation is a non-altruistic "bargain" negotiated between labor and industry.

Unlike social insurance plans, like Medicare and Medicaid, workers' compensation health care costs are not passed onto society through taxes. Injured worker health care and wage replacement costs are paid exclusively by the employer, often through private workers' compensation insurance plans. If the employer purchases insurance to subsidize these costs then the employer's cost, the premium, fluctuates based on the hazards of the employer's industry.<sup>4</sup> These costs are then arguably

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<sup>1</sup> LEX K. LARSON & ARTHUR LARSON, *WORKERS' COMPENSATION LAW: CASES, MATERIALS, AND TEXT* 9 (5th ed. 2013).

<sup>2</sup> Price V. Fishback & Shawn Everett Kantor, *The Adoption of Workers' Compensation in the United States, 1900-1930*, 41 J.L. & ECON. 305, 306 (1998) (outlining the historical adoption of workers' compensation in the United States while specifically highlighting the competing interests backing its proliferation in state law).

<sup>3</sup> *Id.*

<sup>4</sup> See Randy Sieberg, *What is the Role of a Workers Compensation Underwriter?*, WORKERS COMPENSATION CONSULTANTS (Oct. 3, 2014), <http://www.workcompconsultant.com/blog/>

transferred to consumers of the employer's products or services.<sup>5</sup>

Workers, employers, healthcare providers, policy makers, and insurers often mistakenly view workers' compensation benefits the same way they view government entitlement programs because the recipients of care, injured workers, do not have a direct hand in paying for the cost of care. Yet, workers' compensation is as valuable, if not more so, to employers as it is to their employees because it shields them from exposure to tort liability. By statute, workers' compensation is often the only remedy available to injured workers because the *quid pro quo* arrangement bars tort suits against their employers.<sup>6</sup> An employer becomes strictly liable for health care costs stemming from compensable work injuries but enjoys immunity from unpredictable and often costly tort litigation. Workers' compensation laws provide less compensation for injuries than injured workers might recover under tort law, but generally the hurdle to receive care and compensation is far lower.<sup>7</sup> Hypothetically this compromise guarantees injured workers easier access to benefits in return for waiving the right to sue a negligent employer.

Because of the nature of workers' compensation, some might expect workers and employers to be continuously negotiating benefits. However, since the codification of workers' compensation the quality and accessibility of worker benefits are often a secondary concern to the cost of workers' compensation insurance to employers. State legislatures often take the view that workers' compensation is a burden on employers instead of a negotiated bargain between employers and workers.<sup>8</sup> Frequently the cost of workers' compensation assumed by employers incites more conversation in state congresses than benefits afforded or forfeited by workers.<sup>9</sup>

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posts/what-is-role-of-workers-compensation-underwriter/. Sieberg outlines these five sources of information when underwriting risk for workers' compensation policies: the application for coverage, safety records, inspection reports, experience rating worksheets and loss history.

<sup>5</sup> *But see* J. PAUL LEIGH ET AL., COSTS OF OCCUPATIONAL INJURIES AND ILLNESSES 180–81 (2000) (arguing that a substantial portion of the costs of workers' compensation is transferred to employees through lower wages).

<sup>6</sup> Dean M. Hashimoto, *The Future Role of Managed Care and Capitation in Workers' Compensation*, 22 AM. J.L. & MED. 233, 237 (1996).

<sup>7</sup> *Id.* at 237–38.

<sup>8</sup> George A. Amedore, Jr., *Senators Call for Sensible Workers' Comp Reform in Budget*, NEW YORK STATE SENATE (Mar. 22, 2017), <https://www.nysenate.gov/newsroom/press-releases/george-amedore-jr/senators-call-sensible-workers-comp-reform-budget> (In recent debates in the New York senate assembly, John T. McDonald III stated, “[e]mployers, small and large, continue to struggle with the high cost burden of workers' compensation cost. It is the number one or two concern in their business.”).

<sup>9</sup> *See* Martha T. McCluskey, *The Illusion of Efficiency in Workers' Compensation “Reform”*, 50 RUTGERS L. REV. 657, 680–81 (1998) (arguing that “the original workers' compensation bargain was distorted over the past two decades [1970s-80s] because of an expansion of workers' benefits and the increased costs of administering a system with more generous benefits covering a wide range of injuries” which subsequently lead states to implement cost cutting mechanisms).

*B. Legal Structure of Workers' Compensation*

By the 1940's every state had established a workers' compensation system that held employers liable for work related injuries and disease.<sup>10</sup> In Oregon, employer liability is strict in nature but in order to receive benefits workers must meet the following criteria: 1) an injury or illness exists 2) the injury or illness arose out of the course and scope of employment, and 3) the injury or disease was accidental.<sup>11</sup> Workers' compensation benefits are the exclusive remedy for injuries arising out of or in the course of employment.<sup>12</sup> These benefits do not allow for pain and suffering damages.<sup>13</sup> An employee may recover damages through a civil lawsuit against an employer if the employer failed to comply with Oregon workers' compensation law.<sup>14</sup> This incentivizes employers to strictly adhere to the workers' compensation coverage scheme.

Injured workers are limited to three types of benefits: medical, time loss, and vocational.<sup>15</sup> Medical costs associated with accepted workers' compensation claims are the responsibility of the employer. Employers who are not self-insured must contract with insurers to provide coverage for these costs.<sup>16</sup> In return, insurers contract with state approved workers' compensation MCOs to manage the treatment of accepted claims. Medical providers (not subject to MCO contracts) are reimbursed pursuant to the Oregon Worker's Compensation Fee Schedule for necessary treatment provided in relation to an accepted claim. If an injured worker is enrolled in an MCO then a negotiated contract between the physician group, the MCO, and the insurer provides for the physician reimbursement rate.<sup>17</sup>

"Time loss benefits" is a term of art for compensation benefits owed to injured workers who have valid injury or disease claims that required them to miss work or

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<sup>10</sup> Jack J. Burrieschi, *Historical Summary of Workers' Compensation Laws*, CONN. GEN. ASSEMBLY, OFFICE OF LEGIS. RES. REPORT (Mar. 7, 2001), <https://www.cga.ct.gov/2001/rpt/2001-R-0261.htm>.

<sup>11</sup> William H. Replegle, *Workers' Compensation Laws: Oregon, Practical Law State Q&A*, WESTLAW (2018), [https://uk.practicallaw.thomsonreuters.com/w-000-4645?\\_lrTS=20180815025053183&transitionType=Default&contextData=\(sc.Default\)&firstPage=true&comp=pluk](https://uk.practicallaw.thomsonreuters.com/w-000-4645?_lrTS=20180815025053183&transitionType=Default&contextData=(sc.Default)&firstPage=true&comp=pluk).

<sup>12</sup> *Id.*

<sup>13</sup> Hashimoto, *supra* note 6, at 238.

<sup>14</sup> OR. REV. STAT. § 656.020 (2017).

<sup>15</sup> OR. WORKERS' COMPENSATION DIV., OREGON WORKERS' COMPENSATION: FREQUENTLY ASKED QUESTIONS, <https://wcd.oregon.gov/Publications/5126.pdf> (last visited Sept. 4, 2018).

<sup>16</sup> OR. REV. STAT. § 656.029(1) (2017) ("If a person awards a contract involving the performance of labor . . . the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals . . .").

<sup>17</sup> *Billing SAIF*, SAIF CORPORATION, <https://www.saif.com/medical/billing.html> (last visited Sept. 3, 2018).

interfered with their ability to fulfill their pre-injury job duties.<sup>18</sup> Benefits awarded before a claim is closed are called “temporary disability” while benefits awarded after a claim is closed are called “permanent disability.” An injured worker’s attending physician<sup>19</sup> may authorize time loss benefits for a claim up until the worker is “medically stationary.”<sup>20</sup> These benefits are paid to injured workers that either cannot work or are limited in the amount or intensity of the work they can perform.<sup>21</sup> Injured Oregon workers may receive up to 66.67% of their monthly income while qualifying for temporary disability.<sup>22</sup> When a worker is considered medically stationary and their claim is closed, the attending physician may rate any lingering disability for total or partial permanent disability.<sup>23</sup> Compensation benefits are then

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<sup>18</sup> *Injured Worker Benefits*, SAIF CORPORATION, <https://www.saif.com/employer/filing-and-managing-a-claim/injured-worker-benefits.html> (last visited Sept. 3, 2018).

<sup>19</sup> Pursuant to OR. ADMIN. R. 436-009-0005 (2018), the title “attending physician” can apply to health care professionals other than medical doctors, though there are strict limits on non-medical doctors’ abilities to continuously see injured workers and authorize time loss benefits. See *infra* Part IV-A-1 for more discussion.

<sup>20</sup> OR. REV. STAT. § 656.005(17) (2017) (“Medically stationary” means that no further material improvement would reasonably be expected from medical treatment or the passage of time.”).

<sup>21</sup> John F. Burton Jr., *An Overview of Workers’ Compensation*, 7 WORKERS’ COMPENSATION POL’Y REV. 3, 8 (2007).

<sup>22</sup> OR. REV. STAT. § 656.210(1) (2017) (“[W]orker shall receive during the period of that total disability compensation equal to 66-2/3% of wages, but not more than 133 percent of the average weekly wage nor less than the amount of 90% of wages a week or the amount of \$50 a week, whichever amount is less.”); TEX. DEP’T OF INS., WORKERS’ COMPENSATION RES. GROUP, COMPARISON OF STATE WORKERS’ COMPENSATION SYSTEMS 13 (2003) (comparing the average disability payout between all 50 states). Oregon’s temporary disability rate of 66.67% aligns with the national average. Rhode Island has the lowest rate at 57% and Iowa, Alaska and Maine are tied for the highest rate at 80%. Unlike some jurisdictions, Oregon does not cap the duration of temporary disability. In comparison, Texas with a relatively high temporary disability rate of 75% caps its benefit duration at 104 weeks. It should also be noted that Oregon caps weekly temporary total disability at 133% of the average weekly state wage. This translates to roughly \$1,007.05. In comparison, Mississippi caps its maximum weekly temporary disability benefit at \$331.06. Compare OR. DEP’T OF CONSUMER AND BUS. SERV., CENT. SERV. DIVISION / INFO. TECH. AND RES. SECT., OR. WORKERS’ COMPENSATION BENEFITS (2016) & OR. DEP’T. OF CONSUMER AND BUS. SERVS., WORKERS’ COMPENSATION DIVISION, BULL. NO. 111 (REVISED), COMPUTATION OF TEMPORARY DISABILITY, PERMANENT DISABILITY, AND DEATH BENEFITS BASED ON OREGON’S STATE AVERAGE WEEKLY WAGE (June 6, 2018) (showing Oregon’s updated average weekly wage) with *Workers’ Compensation: State by State Comparison Infographic*, BACHUS & SCHANKER LLC, <http://www.coloradolaw.net/news/workers-compensation-state-by-state-comparison-infographic/> (last visited Sept. 3, 2018).

<sup>23</sup> Oregon’s statutory framework for rating disability is similar to the AM. MED. ASS’N, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT 1–5 (4th ed. 1993). See *Understanding the Permanent Disability Rating System*, DISABILITY SECRETS, <http://www.disabilitysecrets.com/resources/understanding-permanent-disability-rating-system.htm> (last visited Sept. 3, 2018).

awarded based on the rated percentage of impairment.

Consider an injured worker who received surgery after suffering a compensable herniated L3-L4 disc injury related to lifting a heavy box at work. Once the worker is determined medically stationary his attending physician may conclude he lost 5% of the range of motion in his lower back. Now assume he also lost some sensation, equal to 2%, due to the surgery. The surgery by itself—because it affected two spine levels of the back—equals another 10%. A formula is then used to combine all the percentages of impairment types to calculate a “whole body” percentage. The combined percentage is then multiplied by Oregon’s average weekly wage to come up with the award amount. For example, a 15% impairment is multiplied by \$1,007.05—Oregon’s average weekly wage as of June 30, 2018—for a total permanent impairment award of \$15,105.75.<sup>24</sup> This amount is awarded as a lump sum to the injured worker for permanent impairment.

These computations are the insurer’s responsibility and are provided to the injured worker in a “notice of closure” letter. It is therefore monetarily beneficial for insurers to close claims as soon as possible to avoid costly temporary disability payments. Equally important is procuring effective treatment for injured workers to maintain the lowest possible impairment rating at claim closure. As insurers rely more on MCOs dedicated to workers’ compensation there is a greater opportunity for claim closure efficiency because MCO physicians, who regularly treat workers’ compensation patients, have a familiarity with the intricacies of workers’ compensation system and can effectively navigate the legalese of “disability,” “medically stationary,” and “compensability.”<sup>25</sup>

### III. HEALTH CARE COST CONTAINMENT

#### A. *The Managed Care Model*

As stated in Part II-A, workers’ compensation is unique because a worker entitled to care has no monetary incentive to act as a prudent consumer of medical care. Employers and insurers pay the entirety of health care costs associated with accepted conditions. Conversely, employer sponsored medical plans allocate a portion of an employee’s healthcare cost on the employee. This incentivizes employees to choose plans with lower monthly premiums and ration their healthcare usage to retain monthly income.<sup>26</sup> Because workers do not engage in the cost management of workers’ compensation states have looked to alternative methods of cost control for

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<sup>24</sup> See *Wage Loss Benefits (Time Loss)*, OR. DEP’T OF CONSUMER & BUS. SERV., <https://www.oregon.gov/DCBS/OIW/Pages/time-loss.aspx> (last visited Sept. 3, 2018) (further detailing the process of awarding permanent disability).

<sup>25</sup> Compensability is discussed in detail *infra* Part IV-A-3.

<sup>26</sup> Debra T. Ballen, *The Sleeper Issue in Health Care Reform: The Threat to Workers’ Compensation*, 79 CORNELL L. REV. 1291, 1293 (1994) (explaining the higher relative cost of workers’ compensation healthcare to that of traditional healthcare by detailing the economic

health care costs.<sup>27</sup> Notably, this has included the statutory implementation of “managed care” to control “price and use” of care and limit injured worker options for treatment.<sup>28</sup>

An MCO contract is an agreement between a group of physicians to provide specific health services, subject to utilization and quality of care considerations, in exchange for reduced payments by a third-party payer.<sup>29</sup> Enrollees of MCOs are restricted to specific physician networks authorized to provide care. Receiving treatment from a physician outside of the network is generally not reimbursed through the insurer. The contract between the providers and the MCO designates the class of enrollees the providers may serve, the services they may provide, and the amount of reimbursement payments.<sup>30</sup>

While reimbursement rates for services performed by physicians are historically lower in MCO than fee-for-service, the physicians benefit from a steady flow of business and revenue. This transfers risk from third-party administrators to providers who assume the uncertainty that increased patient volume will offset the decrease in individual gross charges.

Furthermore, in square opposition to fee-for-service models, managed care monetarily incentivizes providers to ration treatment.<sup>31</sup> This is accomplished through the use of capitation. MCOs allocate providers a capitated amount of money for a designated period for population of patients.<sup>32</sup> The less amount of the capitation spent on patient care the more revenue providers retain.

The financial incentives for physicians in MCOs have, at times, worried health care consumers who generally assume “more health care is better health care.”<sup>33</sup> Yet, “[f]ew tests or procedures are entirely risk free” and incidental findings during care can often lead to unnecessary anxiety and costs for patients.<sup>34</sup> Since workers’ com-

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incentives absent from the workers’ compensation system).

<sup>27</sup> Alternatively, some have argued that greater costs can be found in a federal workers’ compensation system that parallels Medicare and Medicaid. See generally Joan T.A. Gabel, *Escalating Inefficiency in Workers’ Compensation Systems: Is Federal Reform the Answer?*, 34 WAKE FOREST L. REV. 1083 (1999).

<sup>28</sup> McCluskey, *supra* note 9, at 847.

<sup>29</sup> *Managed Care: Managed Costs or Managed Medicine?*, FINDLAW, <http://corporate.findlaw.com/law-library/managed-care-managed-costs-or-managed-medicine.html> (last visited Sept. 3, 2018).

<sup>30</sup> *Id.*

<sup>31</sup> Lisa A. Krouse, *Managed Care and Workers’ Compensation*, 33 TORT & INS. L.J. 849, 850 (1998).

<sup>32</sup> *Id.* at 850–51.

<sup>33</sup> JOHN F. MONAGLE & DAVID C. THOMASMA, HEALTH CARE ETHICS: CRITICAL ISSUES FOR THE 21ST CENTURY 443 (2005).

<sup>34</sup> *Id.*

pensation deals specifically with the treatment of “accepted conditions” and not ancillary health concerns covered under a general insurance plan, it is reasonable to use a system that is sensitive to overtreatment.

Thus, cost incentives combined with the ideological preference of avoiding overtreatment have led many states to retain MCOs as a suitable answer for rising workers’ compensation health care costs.

#### IV. OREGON’S ADOPTION OF COST CUTTING MEASURES

##### A. *Cost Overview: 1980s to Present*

By the late 1980’s, Oregon’s workers’ compensation system was one of the costliest in the country. The state ranked sixth highest in the nation for premium rates and had one of the highest occupational injury and illness rates.<sup>35</sup> Critics of the system argued that the high cost flowed because “too many benefits were provided for questionable disabilities and too many benefits were going to lawyers and dubious care providers.”<sup>36</sup>

In response, then-Governor Neil Goldschmidt convened a management-labor task force (referred to as the Mahonia Hall Group<sup>37</sup>) to tackle the bloated system. During a special session the 1990 legislature passed SB 1197 and 1198, which heightened the compensability standard for work related injuries,<sup>38</sup> eliminated most palliative care for medically stable workers,<sup>39</sup> and authorized the use of state certified MCOs to manage injured worker health care.<sup>40</sup>

The fiscal effect of SB 1197 and 1198 on the workers’ compensation insurance market is undeniable. Since the 1990s, employer premiums for workers’ compensation insurance have dramatically declined. As of 2016 Oregon employers, on average, pay \$1.28 in workers’ compensation premiums per \$100 of payroll.<sup>41</sup> For comparison, Oregon’s southern neighbor California pays almost two and half times that

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<sup>35</sup> OR. DEP’T OF CONSUMER AND BUS. SERVS., 2014 REPORT ON THE OREGON WORKERS’ COMPENSATION SYSTEM 3 (2014) [hereinafter 2014 REPORT].

<sup>36</sup> LEGISLATIVE COMM. SERVS., BACKGROUND BRIEF ON WORKERS’ COMPENSATION 2 (Sept. 2014) [hereinafter BACKGROUND BRIEF].

<sup>37</sup> In reference to the Governor’s mansion where the task group met.

<sup>38</sup> BACKGROUND BRIEF, *supra* note 36, at 2 (“The definition of ‘compensable injury’ was changed to require work exposure to be the ‘major contributing cause’ of some conditions in order to qualify for benefits.”).

<sup>39</sup> 2014 REPORT, *supra* note 35, at 3.

<sup>40</sup> BACKGROUND BRIEF, *supra* note 36, at 4; OR. DEP’T OF CONSUMER AND BUS. SERVS., MANAGED CARE IN THE OREGON WORKERS’ COMPENSATION SYSTEM 3 (1999) [hereinafter OREGON MCO REPORT 1999]; OR. REV. STAT. § 656.260(1) (2017).

<sup>41</sup> Chris Day et al., 2016 Oregon Workers’ Compensation Premium Rate Ranking Summary, OREGON DEP’T OF CONSUMER AND BUS. SERVS. (Oct. 2016), <https://www.oregon.gov/dCBS/reports/Documents/general/prem-sum/16-2082.pdf>.



amount—\$3.24 per \$100 of payroll.<sup>42</sup> Further, it is doubtful these premium rates have leveled out. In its annual report, the Department of Consumer and Business Services (DCBS) announced that the 2017 rate will drop by another 6.6% and “mark[] the fourth year in a row—and eighth year in the past decade—that businesses will experience an average decrease in the ‘pure premium.’”<sup>43</sup>

### 1. *Statutory Managed Care*

Section 260 of chapter 656 of the Oregon Revised Statutes outlines the certification process for MCOs.<sup>44</sup> When the director of the DCBS certifies MCOs pursuant to these statutory requirements an MCO is allowed to contract with insurers and self-insured employers to provide care for injured workers.<sup>45</sup> While MCOs retain broad freedom in their treatment and utilization standards, they must include the following eight types of medical service providers: chiropractors, naturopaths, acupuncturists, osteopaths, dentists, optometrists, podiatrists, and physicians.<sup>46</sup>

In Oregon, as in four other states, injured workers are allowed to choose their treating physician unless their employers or employer’s insurer has a standing contract with an MCO for workers’ compensation care.<sup>47</sup> The mandatory switch to an MCO medical provider may occur at any time after making an injury or disease claim.<sup>48</sup> The injured worker may continue treatment with their non-MCO doctor for seven days after notification of enrollment. After the seven-day period the insurer or employer is no longer required to reimburse the non-MCO medical provider. Time loss benefits authorized under the non-MCO medical provider will also lapse if the injured worker does not transfer care to the MCO.<sup>49</sup> The worker may keep their medical provider if the “physician or nurse practitioner agrees to comply with the rules, terms and conditions regarding service performed” under the specific MCO contract<sup>50</sup> or if the worker’s primary residence is 100 miles outside the

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<sup>42</sup> *Id.* (see Table 2 for workers’ compensation premium rate ranking for all 50 states and Washington D.C.).

<sup>43</sup> *Workers’ Compensation Costs to Drop for Fourth-Straight Year*, OR. DEP’T OF CONSUMER AND BUS. SERV. (Sept. 21, 2016), <https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=1363>.

<sup>44</sup> OR. REV. STAT. § 656.260 (2017).

<sup>45</sup> *Id.* § 656.260(1) specifically prohibits the certification of insurer or employer owned managed care organizations for workers’ compensation by the DCBS.

<sup>46</sup> 2014 REPORT, *supra* note 35, at 33.

<sup>47</sup> TEX. DEP’T OF INS., *supra* note 22, at 7.

<sup>48</sup> OR. REV. STAT. § 656.245(4)(a) (2017).

<sup>49</sup> *Id.*

<sup>50</sup> The Oregon courts read the statute liberally to favor nonmember physicians’ right to treat injured works if they comply with MCO standards. *See* *Managed Healthcare Nw., Inc., and Providence Health Plan, Inc. v. Dept. of Consumer and Bus. Services*, 106 P.3d 624, 626 (2005) (denying MCOs the ability to use past treatment practices against a non-MCO member physician as a way to deny non-MCO member physicians, who agree to comply with MCO terms, to treat

MCO's geographical area.<sup>51</sup>

In 2015, Oregon had four certified MCOs with approximately 111 active contracts with insurers and self-insured employers.<sup>52</sup> These MCOs oversaw 48% of workers with disabling claims.<sup>53</sup> The State Accident Insurance Fund (SAIF)<sup>54</sup> enrolled 69% of claimants with accepted disabling claims in MCOs compared to self-insured employers who enrolled 40% of claimants with disabling claims and private insurers who enrolled only 10% of claimants.<sup>55</sup>

The total number of certified active MCOs fell from 16 in 1998 to only four in 2015 but the number of MCO contracts rose from 85 to 111.<sup>56</sup> As the number of MCOs declines, a larger share of the workers' compensation healthcare market becomes concentrated into fewer physician networks. It is likely that large regional hospitals, such as Kaiser and Providence who curate their own MCOs, will continue to edge out the competition and eventually swallow the market.

## 2. *Immunity to Suit*

In order for an MCO to be certified, the director of the DCBS must find that, among other things, the plan includes the use of "service utilization review."<sup>57</sup> MCOs employ service utilization review on a case-by-case basis to "assess, improve, and review treatment decision."<sup>58</sup> This review process plays an important role in "ensur[ing the] appropriate use of resources,"<sup>59</sup> which addresses rising medical costs by adding a check on frivolous medical tests and treatment.

By statute, these review committees must include a majority of "physicians licensed to practice medicine by the Board of Medical Examiners." Interestingly, the decisions made by these committees regarding care are not considered medical and are immune from civil malpractice suits.<sup>60</sup>

The Oregon Supreme Court outlined MCO statutory immunity in *Kahn v.*

injured workers).

<sup>51</sup> § 656.245(4)(a).

<sup>52</sup> OR. DEP'T OF CONSUMER AND BUS. SERVS., 2016 REPORT ON THE OREGON WORKERS' COMPENSATION SYSTEM 37 (2016) [hereinafter 2016 REPORT].

<sup>53</sup> *Id.* This was a 3% increase from 2013. See 2014 REPORT, *supra* note 35, at 34.

<sup>54</sup> The State Accident Insurance Fund (SAIF) is a not-for-profit quasi-governmental workers' compensation insurer set up by the State of Oregon in 1914. Currently, the corporation holds 51.7% of the workers' compensation premium market share in Oregon. See *SAIF Fact Sheet*, SAIF (May 2018), [https://www.saif.com/Documents/AboutSAIF/G246\\_SAIF\\_Facts.pdf](https://www.saif.com/Documents/AboutSAIF/G246_SAIF_Facts.pdf).

<sup>55</sup> 2016 REPORT, *supra* note 52, at 37.

<sup>56</sup> Compare 2016 REPORT, *supra* note 52, at 37 with OREGON MCO REPORT 1999, *supra* note 40, at 2.

<sup>57</sup> OR. REV. STAT. § 656.260(4)(d) (2017) (The "director" refers to the director of The Department of Consumer and Business Services).

<sup>58</sup> OREGON MCO REPORT 1999, *supra* note 40, at 5.

<sup>59</sup> § 656.260(4)(d)(B).

<sup>60</sup> OR. REV. STAT. § 656.260(8).

*Providence Health Plan*.<sup>61</sup> The plaintiff in *Kahn* brought a negligence suit against Providence Health Plan MCO for ruling that a back surgery her MCO physician recommended was not necessary.<sup>62</sup> Normally, the director of the DCBS handles disputes over service utilization review decisions through an administrative process.<sup>63</sup> The plaintiff, who subsequently received the surgery attempted to usurp the administrative process by bringing a claim for damages stemming from the delay in surgery and not for the execution of the disputed surgery. The court reasoned that the board's action denying the surgery was an "affirmative action" taken in "good faith" and therefore the MCO was statutorily immune from a suit for damages.<sup>64</sup> The court did not discuss what factors it entertains when deciding if a decision is made in "good faith." The ruling ensured that service utilization review decisions are afforded the type of latitude that allows MCOs, in "good faith," to disregard civil liability when denying treatment.

Allowing MCOs to deny treatment, which has tangible medical implications on patients without the check of malpractice or civil liability, strengthens their ability to ration treatment and further mitigate health care costs. Yet critics argue that, if abused, this system dishonors the employer-employee workers' compensation bargain by focusing on efficiency and cost instead of worker care.<sup>65</sup>

### 3. *Heightened Compensability Standards to Curb Costs*

Since the late 1980s, the definition of compensability has been revised by the Oregon legislature multiple times. These changes have restricted the number of accepted claims.<sup>66</sup> In response, Oregon's judiciary has at times ruled in favor of expanding the definition of compensability under Oregon workers' compensation laws.<sup>67</sup> This has led to an awkward and unnecessarily complicated statutory

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<sup>61</sup> *Kahn v. Providence Health Plan*, 71 P.3d 63, 64 (2003).

<sup>62</sup> *Id.*

<sup>63</sup> OR. REV. STAT. § 656.260(7) (2017) (Unlike issues of compensability that are handled by the hearings division of the Workers Compensation Board, the director is the sole decider in "[a]ny issue concerning the provision of medical services to injured workers subject to a managed care contract . . .").

<sup>64</sup> *Kahn*, 71 P.3d at 66; § 656.260(9) provides:

A person participating in service utilization review, quality assurance, dispute resolution or peer review activities pursuant to this section shall not be examined as to any communication made in the course of such activities or the findings thereof, nor shall any person be subject to an action for civil damages for affirmative actions taken or statements made in good faith.

<sup>65</sup> McCluskey, *supra* note 9, at 721–23.

<sup>66</sup> 2014 REPORT, *supra* note 35, at 21; *See e.g.* Terry Thomason & John F. Burton, Jr., *The Effects of Changes in the Oregon Workers' Compensation Program on Employees' Benefits and Employers' Costs*, 1 WORKERS' COMPENSATION POL'Y REV. 7, (2001) (changes made to the Oregon statute reduced the number of claims by 12–28% and benefits by 20–25% between the late 1980's and 1996).

<sup>67</sup> *See Smothers v. Gresham Transfer, Inc.*, 23 P.3d 333, 361 (2001). The Oregon Supreme

scheme.<sup>68</sup>

Compensability of a work-related medical condition is likely the most litigated issue in workers' compensation. The medical condition is then determined to be either an *injury* or an *occupational disease*. *Injuries* are abrupt, such as breaking a bone when falling down the stairs, while *occupational diseases* occur from gradual exposure to work conditions over time, such as a respiratory disease from inhaling chemicals.

The distinction between an *injury* and an *occupational disease* is paramount, as Oregon has adopted a higher standard for medical causation for occupational diseases. For injuries, the worker need only prove the injury was a "material cause," meaning a substantial or important cause, but not necessarily the only cause. Conversely, for an occupational disease, the worker must prove work exposure is the "major contributing cause," or responsible for greater than 50% of the condition. The analysis is complicated when an otherwise compensable injury combines with a "qualified preexisting condition[]" (QPC)<sup>69</sup> to create a new condition. These new conditions are called "combined conditions" and compensability requires the "major contributing cause" standard.

For example, if a worker with preexisting degenerative disc disease ("DDD") in his cervical column suffers a cervical sprain on the job, the cervical strain, by itself, is undoubtedly an acute injury and compensable. Yet, the worker might be denied treatment for long-term radicular symptoms in his legs that manifest after the sprain. This is because the radicular symptoms likely stem from the combination of the acute cervical strain with the preexisting DDD. This new "combined condition," the cervical strain combined with the DDD, is compensable for radiculopathy only if the "major contributing cause" of the radiculopathy is the compensable cervical

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Court declared that the major contributing cause standard passed under SB 369 was unconstitutional where it deprived a claimant of a remedy that the claimant would have had at common law. This holding did not invalidate the standard, rather, it permitted a claimant to sue the employer directly in civil court for damages caused by the employer's negligence in cases where the standard left the claimant without a remedy that he or she would have otherwise been entitled to. The Legislature was wary that the decision would lead to an uptick in worker claims against employers. The effect on employers has been negligible and the court subsequently overruled *Smothers* in *Horton v. OHSU*, 376 P.3d 998, 1005 (Or. 2016).

<sup>68</sup> In a 2017 decision by the Oregon Supreme Court regarding the definition of "injury" Justice Landau exemplified this tension expressing that "[t]here is little that is 'plain' about [Oregon's] workers' compensation statutes. . . . In fact, there appears to be a tendency on the part of the legislature to use a number of different terms in not altogether consistent fashion, sometimes treating them as essentially synonymous and at other times treating them as signifying different things." *See Brown v. SAIF Corp.*, 391 P.3d 773, 779 (Or. 2017).

<sup>69</sup> OR. REV. STAT. § 656.005(24)(a) (2017) ("qualified preexisting conditions" specifically refers to conditions that have been previously diagnosed or the that worker has previously obtained medical services for the condition. Arthritis and arthritic conditions are always considered "preexisting conditions" regardless of prior diagnosis or treatment.).

strain.<sup>70</sup> The insurer need only prove that the DDD, not the cervical strain, is the major contributing cause of the cervical radiculopathy. It is often immaterial that radiculopathy was precipitated by an acute injury because a minor acute injury is unlikely to be the major contributing cause of the combined condition. Insurers and employers actively develop medical evidence in order to argue that a combined condition exists and that the preexisting condition, rather than the acute injury, is the major contributing cause of the combined condition.

Since workers' compensation MCOs only treat compensable claims, injured workers will not receive treatment for combined conditions once the condition is deemed medically stationary. In practice, this means that a worker with a combined condition stops receiving treatment for symptoms precipitated by work once the work injury is no longer the major contributing cause. Therefore, a worker with an asymptomatic preexisting condition that combines with minor acute work injury has an uphill battle to receive treatment for the now-symptomatic preexisting condition once the acute work injury is considered medically stationary.

This scenario presents a problem that workers' compensation is not adept at handling. If a worker does not have private health insurance or cannot afford the price of treatment through private health insurance to cover a non-work-related injury, the worker may attempt to fit their injury within the workers' compensation scheme.<sup>71</sup> This inherently creates cost shifting between workers' compensation insurance and private or public insurance.<sup>72</sup>

Prior to 1990, Oregon's compensability standard did not use the "major contributing cause" standard or consider "qualified preexisting conditions." The employer simply "took the worker as he found him" and shouldered the added cost burden.<sup>73</sup> The "major contributing cause" is the highest standard of proof for any

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<sup>70</sup> OR. REV. STAT. § 656.005(7)(a)(B) (2017) ("the combined condition is compensable only if . . . the otherwise compensable injury is the major contributing cause of the disability of the combined condition . . ."); *See also* Vigor Industrial, LLC v. Ayres, 310 P.3d 674, 681 (Or. Ct. App. 2013) (holding that the major contributing cause of a combined condition was when the injury is a greater cause than the qualified preexisting condition).

<sup>71</sup> HELMSMAN MANAGEMENT SERVICES, HOW WILL THE AFFORDABLE CARE ACT IMPACT WORKERS COMPENSATION? (Sept. 2014), [https://helmsmantpa.com/Documents/HMS\\_ACA+WC\\_White+Paper.pdf](https://helmsmantpa.com/Documents/HMS_ACA+WC_White+Paper.pdf) ("Another potential negative, noted above, is that workers injured away from the job could decide they can't afford their health plans' deductibles and co-payments and may seek to utilize the workers compensation system for their treatment.").

<sup>72</sup> *Id.* The article argues that that "workers injured away from the job could decide they can't afford their health plans' deductibles and co-payments and may seek to utilize the workers compensation system for their treatment." Furthermore, ACA's health care mandate on employers may lead employers to rely on part-time employees to escape the mandate's requirements. This could lead to further cost shifting to workers' compensation for workers who do not have access to subsidized employment healthcare plans.

<sup>73</sup> EDWARD M. WELCH, FINAL REPORT OREGON MAJOR CONTRIBUTING CAUSE STUDY 105 (2000).

U.S. state.<sup>74</sup> Since Oregon's statutory introduction of the "major contributing cause" standard, the number of accepted disability claims fell from a high of 43,660 in 1988 to a low of 18,011 in 2010.<sup>75</sup> This correlates to a decline from 3.8 accepted claims per 100 employees to 1.1 accepted claims per 100 employees.<sup>76</sup> The heightened "compensability" standard and concerted effort by insurers and MCOs to adhere to that standard have been effective in curbing the number of accepted claims.

## V. FUTURE CONSIDERATIONS FOR OREGON'S COMPENSATION SYSTEM

While Oregon's workers' compensation system has evolved into a cost saving model for other states, there are still opportunities for greater efficiency and focus on worker care. These include greater utilization of healthcare professionals as "attending physicians" and cost containment of independent medical exams.

### A. *Expanding the Role of Non-Physicians*

Discussed in Section II-B, an injured worker's "attending physician" is principal in directing a worker's treatment, authorizing time loss benefits, and determining when a condition is medically stable. Prior to 2003, under statute, only doctors of medicine, osteopathy, or maxillofacial surgery were authorized to act as "attending physicians" and provide compensable medical services to workers without a referral.

In 2003, HB 3669 expanded the role of nurse practitioners (NPs) in three ways. The bill 1) allowed NPs to provide medical services for compensable claims for 90 days, beginning on the date of the first visit, 2) granted NPs the ability to authorize temporary disability benefits for 60 days, and 3) allowed NPs to release workers back to work.<sup>77</sup> The results of the legislation were studied in 2005 and evinced "no system cost increases related to the expanded authority for nurse practitioners" and showed an "expansion of workers' ability to continue treatment with providers with whom they had established relationships."<sup>78</sup> Still, the law often resulted in discontinuity of care due to the requirement that NPs refer patients to a

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<sup>74</sup> *Id.* at 25, 107. Arkansas, Florida and South Dakota have also used the major contributing cause standard since the 1990s. All four states are rank below the national payroll average of \$2 per \$100 of wages. See Michael Grabell and Howard Berkes, *The Demolition of Workers' Comp*, PRO PUBLICA (Mar. 4, 2015), <https://www.propublica.org/article/the-demolition-of-workers-compensation>.

<sup>75</sup> 2016 REPORT, *supra* note 52, at 17.

<sup>76</sup> *Id.* This change in overall accepted claims and claim rate is especially telling as Oregon added approximately 700,000 employees under its Workers' Compensation system since 1989. *Id.*

<sup>77</sup> 2016 REPORT, *supra* note 52, at 38.

<sup>78</sup> OR. DEP'T OF CONSUMER AND BUS. SERVS., WORKERS' COMPENSATION CARE PROVIDER STUDY 8 (2006).

new attending physician after 90 days. Transferring care can be costly on the system and the worker, resulting in delays for needed care and duplication of assessments and procedures.<sup>79</sup>

Further lobbying and studies cited by the Oregon Nurses Association, showing that “outcomes for care provided by advanced practice nurses, including Nurse Practitioners are similar to and in some ways better than care provided by physicians alone,”<sup>80</sup> lead to the passage of SB 533 which extended the treatment and time loss authorization period to 180 days.

In 2007, HB 2756 expanded the “role of chiropractors, podiatrists, naturopaths and physician assistants to act as attending physician[s]” for 18 visits or 60 days.<sup>81</sup> Yet, NPs are still not authorized to be attending physicians for more than 180 days.

Some have argued, specifically in light of an apparent shortage of primary care physicians, that health care providers who are competent to provide care should not be artificially restricted by historical notions of “scope of practice.”<sup>82</sup> Allowing NPs to assume the role of “attending physician” would allow more choice in care for injured workers and potentially lower the cost of providing care.

#### *B. Reevaluating Costs Associated with Independent Medical Exams*

Insurers use independent medical exams (IMEs) to evaluate injuries and diseases to determine the compensability of conditions and to close claims. By statute, an insurer may request as many as three IMEs per claim.<sup>83</sup> When there is a dispute between medical experts regarding a condition, more weight is given to those medical opinions which are both well-reasoned and based on complete information.<sup>84</sup> Medical disputes over claims create a “medical opinion arms race” between the insurer and injured worker. The winning party is usually determined by who ever gathers the most medical opinions that support their theory concerning the condition. The resulting “battle of the experts” is a costly affair that adds unnecessary

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<sup>79</sup> SB 533: *Nurse Practitioner Treatment Timelines in Workers' Compensation*, Nurse Practitioners of Oregon (2013).

<sup>80</sup> SARAH BAESSLER, NURSE PRACTITIONERS OF OREGON, TESTIMONY IN SUPPORT OF SB 533 WITH -2 AMENDMENTS: HEARING ON SB 533 BEFORE THE SENATE, S. 2013 Leg., Reg. Sess. (2013) (statement of Sarah Baessler, Director of Health Policy and Government Relations Oregon Nurses Association).

<sup>81</sup> 2016 REPORT, *supra* note 52, at 39. For a full matrix showing the authorization of each medical provider see OR. ADMIN. R. 436-009-0005 (2018), Appendix A.

<sup>82</sup> Barbara J. Safriet, *Federal Options for Maximizing the Value of Advance Practice Nurses in Providing Quality, Cost-Effective Health Care*, in THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 443, 444 (2011).

<sup>83</sup> 2016 REPORT, *supra* note 52, at 38.

<sup>84</sup> *Hammons v. Perini Corp.*, 602 P.2d 1094, 1095 (Or. Ct. App. 1979).

costs on the system.

In 2015, IMEs accounted for 4.2 percent of the total medical payments made through the Oregon workers' compensation,<sup>85</sup> amounting to roughly \$12.5 million.<sup>86</sup> That figure was up 32% (or \$3.92 million) from two years earlier in 2013.<sup>87</sup> Even more alarming is the fact that \$34.8 million *more* dollars were spent on injured workers in 2013 than in 2015. The number of claims accepted in 2013 and 2015 were relatively similar, which may mean that insurers utilized more IMEs to deny claims.

Either the system is spending more money on IMEs to more accurately exclude non-compensable claims or IMEs are being over utilized.<sup>88</sup> Regardless, both scenarios still lead to a rising percentage of the total workers' compensation medical payments going to medical evaluations and not to the treatment of injured workers.

## VI. CONCLUSION

Oregon's workers' compensation system has successfully contained medical costs over the past 28 years, leading to large savings on insurance premiums for employers. Managed care has streamlined injured worker care and likely curbed rising medical costs far more effectively than a legislatively managed fee schedule. Yet, in return, workers are now required to meet a higher burden to prove the compensability of conditions and are subjected to insurer directed care facilitated through a small number of MCOs. Allowing more autonomy for competent medical professionals to care for injured workers and tweaking the compensability standard to curb the use of IMEs could result in a higher percentage of money spent on *actual* care. After all, a lean cost-effective system was not necessarily part of the "grand bargain."<sup>89</sup>

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<sup>85</sup> 2016 REPORT, *supra* note 52, at 38.

<sup>86</sup> *Id.*

<sup>87</sup> 2014 REPORT, *supra* note 35, at 34, 36.

<sup>88</sup> Some claimant attorneys and injured workers argue that insurers routinely abuse the IME system to exclude merited claims. See *Injured Worker Survey Regarding IMEs*, OR. DEP'T OF CONSUMER AND BUS. SERVS., WORKERS' COMPENSATION INSURER MEDICAL EXAMINATION STUDY (2004) ("19 percent had comments regarding the IME physician being biased (i.e. worker felt that the physician had already made up its mind, felt that since the insurer paid the physician the physician would do whatever the insurer wanted.)"). For an out of state opinion that showcases the lack of civility between the claimant's bar and insurers see Jeffery Kaufman, *How Insurance Companies Use IME Doctors to Abuse the Workers Comp System*, MICHIGAN WORKERS' COMPENSATION LAWYERS (February 1, 2011), <http://www.workerscomplawyerhelp.com/blog/2011/02/how-insurance-companies-use-ime-doctors-to-abuse-the-workers-comp-system/>.

<sup>89</sup> SCOTT SZYMENDERA, CONG. RESEARCH SERV., REVIEWING WORKERS' COMPENSATION FOR FEDERAL EMPLOYEES 2 (May 12, 2011) ("Workers' compensation is commonly referred to as 'the grand bargain' between employees and employers.").